DOCUMENT RESUME

ED 436 692 CG 029 685

AUTHOR Schwieger, Jeffrey L.
TITLE An Evaluation of the Effectiveness of Axis I Treatment with a Comorbid Personality Disorder with Implications for the Health Care System: A Review of the Literature.
PUB DATE 1999-12-00
NOTE 55p.; Doctoral Research Paper, Biola University.
PUB TYPE Dissertations/Theses (040) -- Information Analyses (070)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Clinical Diagnosis; *Clinical Psychology; Counseling; Counselor Training; Literature Reviews; Outcomes of Treatment; Psychotherapy; Theory Practice Relationship; Values
IDENTIFIERS Comorbidity; Diagnostic Statistical Manual of Mental Disorders; Partnerships in Health Care

ABSTRACT

This paper examines the relationship between clinical psychology and the health care system. The first part reviews the empirical Axis I disorders with patients who also have a comorbid DSM-IV diagnosed personality disorder. While the understanding and treatment of AI disorders have improved, severe limitations exist when patients use the health care system to pay for any other psychological treatment. The second section uses findings from the first section to discuss the status of clinical psychology's relationship with the health care system. Three perspectives on this relationship are offered. An important focus of this section is the observation that clinical psychologists are not powerless against managed care. Because many psychologists cannot see their own value they allow themselves to be controlled by the health care system. This can lead to an inability to treat patients in a health conscious, ethical, and legal manner. This managed care psychotherapy mindset is also prevalent in graduate programs today. This mindset could be changed if practitioners and students will take a stand for themselves and the integrity of the profession, and not accept the substandard limitations placed on them by the health care system. (Contains 46 references.) (JDM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

CG

ED 436 692

AN EVALUATION OF THE EFFECTIVENESS OF AXIS I TREATMENT WITH A COMORBID PERSONALITY DISORDER WITH IMPLICATIONS FOR THE HEALTH CARE SYSTEM: A REVIEW OF THE LITERATURE.

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

by

Jeffrey L. Schwieger

December, 1999

PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

J. SCHWIEGER

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

BEST COPY AVAILABLE

CG029685

AN EVALUATION OF THE EFFECTIVENESS OF AXIS I TREATMENT WITH A COMORBID PERSONALITY DISORDER WITH IMPLICATIONS FOR THE HEALTH CARE SYSTEM: A REVIEW OF THE LITERATURE.

by

Jeffrey L. Schwieger

APPROVED:

Randall L. Sorenson, Ph.D., Psy.D. Date 9/16/99

Joan Jones, Psy.D. Date 9/16/99

APPROVED:

Patricia L. Pike, Ph.D., Dean

9/16/99
Date

Copyright © 1999 by Jeffrey L. Schwieger

ABSTRACT

AN EVALUATION OF THE EFFECTIVENESS OF AXIS I TREATMENT WITH A COMORBID PERSONALITY DISORDER WITH IMPLICATIONS FOR THE HEALTH CARE SYSTEM: A REVIEW OF THE LITERATURE.

by

Jeffrey L. Schwieger

This paper examines the relationship between clinical psychology and the health care system. The first part of this paper reviews the empirical research supporting the significantly lessened effectiveness in the treatment Axis I disorders with patients who also have a comorbid DSM-IV diagnosed personality disorder, based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 1994). This research indicates that brief psychotherapy or psychopharmacological interventions with these patients usually reduces their Axis I symptoms. However, at the end of their treatment phase, they often continue to meet the criteria for the same Axis I disorder for which they were treated. In the second part of this paper, implications from these findings will be drawn to discuss the current relationship between the health care system and clinical psychology.

TABLE OF CONTENTS

PAGE

DOCTORAL RESEARCH PAPER

Introduction....1

Section One: Empirical Evidence....3

Confounded Treatment of AI/PD Patients....3

Psychotherapy Benefits....11

Diagnosis and Treatment Considerations....13

Long- Versus Short-term Psychotherapy....15

Related Health Issues and Medical Costs....19

Section Two: Implications of Research....21

Expanded Relationship....21

Constricted Relationship....22

The Altered Perception of Psychotherapy....23

Psychotherapy Outside of the HCS....26

Status Quo Relationship....32

Pretreatment Considerations....33

Informed Consent for Managed Care Treatment....38

Discussion....41

REFERENCES....45

AN EVALUATION OF THE EFFECTIVENESS OF AXIS I TREATMENT WITH A COMORBID PERSONALITY DISORDER WITH IMPLICATIONS FOR THE HEALTH CARE SYSTEM: A REVIEW OF THE LITERATURE.

Introduction

This paper examines the relationship between clinical psychology and the health care system (HCS). The field of clinical psychology and the treatment of psychopathology has changed tremendously in the last two decades, especially how the HCS pays for psychological services. One positive change has been the increased theoretical and practical understanding of treating simple Axis I (AI) disorders with brief, succinct, and empirically validated treatments. Severe limitations exist, however, when patients use the HCS to pay for or supplement any psychological treatment other than that of simple AI disorders.

The first part of this paper reviews the empirical research supporting the significantly lessened effectiveness in treating AI disorders with patients who also have a comorbid DSM-IV diagnosed personality disorder (PD; AI/PD patient). One implication that can be drawn from these research findings is that, to adequately treat AI/PD patients, they should receive psychotherapy for their PD prior to, or concurrently with, their AI treatment. An alternative means of deciding which patients are compatible or noncompatible with managed care psychotherapy will also be offered in this section. This alternative way of describing patients' and therapists' goals for

therapy, symptom reduction, or trait change is supported through treatment outcome research and may be more encompassing and less pathologizing than using only DSM-IV criteria. Finally, this section will offer research that supports the many different benefits of psychotherapy, including its cost effectiveness. Specific to the treatment of PDs and trait change, research will be offered which indicates the lasting treatment effects of long-term therapy.

The second section of this paper will be a discussion. Implications from the first section's findings will be used to discuss the status of clinical psychology's relationship with the HCS. Three perspectives on this relationship will be offered. An important focus of this section is the observation that clinical psychologists are not powerless against managed care and have the ability to make choices regarding the nature and scope of their practices, including the nature of their relationships with their patients and the HCS alike.

One perspective on the relationship between psychology and the HCS involves expansion. In an expanded relationship, the HCS would cover all necessary costs of psychological treatment because this, in the long-run, would be more cost effective for the HCS. Many psychologists believe an expanded relationship would sustain their practices and would allow them to treat patients in a conscientious, ethical, and legal manner. Needless to say, these same psychologists see the current relationship as too constricted and blame the HCS for their diminished practices and income, as well as for their inability to treat patients in a health conscious, ethical, and legal manner.

A second perspective involves constriction. In a constricted relationship, the HCS would cover only in-patient and crisis types of

interventions because of cost effectiveness. Many clinical psychologists endorse this option, and primarily or only see out-patients who pay for their services out-of-pocket.

A third perspective entails what could be termed the status quo. The current relationship between clinical psychology and the HCS has been designed by the HCS, which believes it controls the relationship between itself and clinical psychology. For the most part, clinical psychology believes this too. Thus, most psychologists believe that the current relationship with the HCS is all there is to work with--this is clinical psychology now. Clinical psychologists who chose to work with patients whose full or partial payment will be coming from the HCS need to take measures to protect themselves from violating their ethical and legal obligations, especially to provide adequate treatment without abandoning their patient if the patient's provider stops payment before treatment is completed. Therefore, psychologists run an increased risk of violating their ethical and legal obligations when they engage in a therapeutic relationship with a patient, especially when working within the HCS, whose diagnosis is anything other than a simple AI disorder.

Section One: Empirical Evidence

Confounded Treatment of AI/PD Patients

Across the treatment of many different AI disorders, researchers have found and reported on the confounding effects of treating AI symptoms in AI/PD patients. The literature shows that when treating AI/PD patients with time limited therapy, usually only a reduction of symptoms relative to the patient's pretreatment report of symptoms occurs. Although AI/PD patients'

positive AI symptoms decrease, they often still meet the criteria for the AI disorder they were being treated for, not to mention the criteria of their premorbid PD they were not treated for.

Nurnberg, Rifkin, and Doddi (1993) found that, in the outpatient treatment of alcoholics, poorer treatment outcome was associated with the presence of a PD. In their study of 50 sober alcoholic outpatients enrolled in a treatment program, 80% of the patients had either a coexistent AI or PD, 66% had a AI disorder, 64% had a PD, and 50% had both an AI disorder and a PD. Of the 32 patients diagnosed with a PD, 84 PD diagnoses were made (2.6 per patient), and multiple PD diagnoses--two or more PD diagnoses per patient--were found in 20 patients (62%). As indicated by mean averages, PD patients had fewer positive breathalyzer tests than their AI no PD (AI/NPD) treatment counterparts (.19/.22), reported more drinking episodes (.59/.44), missed more days from the program (3.65/2.72), and had fewer weeks of attendance in the program (28.91/35.11). Further, a lower percentage of AI/PD patients entered the next phase of the program (50%/67%). Although these findings indicate poorer treatment outcome for alcoholics with a PD, *t* or chi-square tests did not reveal a significant difference in PD and NPD patients for these particular variables. However, when the Clinical Global Impressions Scale (CGI) was examined, a significant mean average was found in the overall functioning of PD and NPD patients (3.31/2.72).

Cacciola, Rutherford, Alterman, McKay, and Snider (1996) found that methadone maintenance treatment (MMT) in opiate-dependent men is confounded when the patients also meet the criteria for a PD diagnosis. Of the 210 patients that entered treatment, 130 (66%) received a singular or multiple PD diagnosis. The AI/PD patients entered treatment with more

severe self-reported drug, alcohol, psychological, and legal problems than the AI/NPD patients. Further, although both groups of patients made progress in treatment, the AI/PD population remained more problematic in these areas, both at baseline levels and at 7 month follow-up, than the AI/NPD population. AI/PD patients also had a higher treatment drop-out rate than AI/NPD patients. These findings are similar to those of Kosten, Kosten, and Rounsaville (1989) who did the first outcome study on MMT with AI/PD and AI/NPD patients. They found that MMT patients with PDs have poorer legal outcomes, more alcohol addiction problems, and more psychological difficulties than AI/NPD, MMT patients. Most importantly, Kosten et al. also found that AI/PD patients had poorer treatment outcome, in relation to their addiction, than AI/NPD, MMT patients.

An AI population that appears to have a higher rate of PDs than the general population (de Silva & Eysenck, 1987; Norman & Herzog, 1983; Strober, 1981), and whose treatment is confounded by the presence of a PD, is the eating disordered. Wonderlich, Swift, and Slotnick (1990), in their study of eating-disorder patients, used the Structured Clinical Interview for DSM-III-R (SCID-II) to generate DSM-III-R diagnoses, and found that 72% (33 of 42) of their subjects met the criteria for at least one PD. In the specific case of bulimia, they found that 69% (11 of 16) met the criteria for having a PD, the most common being histrionic PD. Fahy, Eisler, and Russell (1993) studied 39 female outpatients with bulimia nervosa, of which 39% (14 of 39) were diagnosed with a PD according to the Personality Assessment Schedule (PAS), a scale which divides PD dimensions into 14 categories. Histrionic and anxious PD, as defined by the PAS, were the most common. All patients in this study received 8 weeks of cognitive-behavioral therapy with follow-

up after 8 weeks and at 1 year. Patients with PDs, at the beginning of treatment, had significantly lower weight (NPD = 61.6kg, PD = 56kg), body mass index (NPD = 22.8 kg/m^2, PD = 20.5 kg/m^2), and were significantly more depressed. Because the authors of this study wanted to assess whether or not the areas of diminished biological and physiological health of the AI/PD patients were due to the difference in outcome between groups (i.e., PDs do not have an independent effect on outcome), they performed a multivariate analysis of covariance (MANCOVA) with repeated measures to assess factors which might covary with PDs. When the factors of depression and body mass index were assessed as covariables at the onset of treatment, the authors found that there was no longer any significant difference between AI/NPD and AI/PD patients.

Although this finding appears to be contradictory to the hypothesis of this paper, the increased reported pathology in the AI/PD patients, when compared to their AI/NPD treatment counterparts, in the above areas of assessment in this study still needs to be addressed. Although Fahy et al. (1993) contend that this study was not designed to study this question, they offer that mood disturbance and anorexic/bulimic pathology are most likely increased in those with PDs. This is supported by the authors' findings that their AI/PD patients, when compared with AI/NPD patients, reported higher levels of pathology via questionnaire measures in the areas of binge frequency, bulimic behavior and psychopathology. Also, at the end of 8 weeks of treatment (end of the active treatment phase), AI/PD patients reported higher levels on all symptom measures, including a significantly higher level of binge frequency. Further, the AI/PD group required a significantly greater number of follow-up sessions at the end of the 8 week

treatment trial than did the AI/NPD group (mean difference of 2.7 vs. 1.2 sessions).

Another Axis I population with a significant number (60%) meeting the DSM-III diagnostic criteria for a comorbid PD, is the group that suffers from chronic pain syndrome (Kinney, Gatchel, Polatin, Fogarty, & Mayer, 1993). In treating patients with chronic pain, Elliot, Jackson, Layfield, and Kendall (1996) found that patients who also have a comorbid PD report higher levels of distress and pain at both the beginning and end of outpatient treatment. Interestingly, little correlation was found between the two control groups in regards to physical therapist ratings of impairment and/or improvement. Using a conservative cutoff base rate of 84 on the Millon Clinical Multiaxial Inventory (MCMI), 66% of those evaluated for the study had personality profiles indicative of a PD. The most significant finding was found in those patients who were diagnosed with both a pain disorder and a Cluster "B" (dramatic) PD. These PDs include Antisocial, Borderline, Histrionic, and Narcissistic. This study found that the greatest correlate of reported distress and pain at the time of discharge, as well as the least amount of pain reduction relative per patient, was an increased Narcissism score on the MCMI.

Reich (1988) found that PDs have a negative effect on the pharmacological treatment of Panic Disorder. In this study, 52 subjects were in the treatment group (28 treated with alprazolam and 24 treated with diazepam) while 28 subjects were treated in the placebo group. All subjects in this study were diagnosed as having Panic Disorder and were further identified as being an AI/NPD or AI/PD patient by one of three measures: the Personality Diagnostic Questionnaire, the MCMI, or the Structured Interview

for DSM-III Personality Disorders. The Hamilton Rating Scale for Depression and the Hamilton Rating Scale for Anxiety were also used to assess depression and anxiety differences between the AI/PD and AI/NPD patients. Subjects who were found to be in the dramatic cluster of PDs (Cluster "B"--borderline, narcissistic, histrionic, and antisocial PD) showed significantly more panic attacks (81% vs. 62%) than the NPD subjects. This cluster also differentiated the AI/(cluster "B") PD and AI/NPD patients by Hamilton anxiety scores (69% vs. 46%). Those subjects diagnosed with avoidant PD were significantly differentiated by Hamilton anxiety scores from those subjects without a PD (75% vs.51%), as well as by Hamilton depression scores (68% vs. 44%), and social leisure disability scores (78% vs. 41%). Those subjects diagnosed with histrionic PD showed significant increases over AI/NPD subjects for number of situational panic attacks (80% vs. 64%), work disability scores (78% vs. 27%), and social disability scores (77% vs. 36%). Reich's study indicates that a poorer response to treatment is found in subjects diagnosed with flamboyant/dramatic cluster PDs. Reich states that the outcome of his study can be considered a strong positive finding.

The pharmacological treatment of depression is confounded by the presence of a PD as well. Sato, Sakado, Sato, and Morikawa (1994) investigated whether or not the presence of a specific PD cluster in patients comorbidly diagnosed with major depression affected their psychopharmacological treatment outcome for their depression. Of the 96 patients in the study, 52 (54%) had a PD of some kind, and 35 (37%) had overlapping (two or more) PDs. The most frequent cluster found was "C"--Avoidant, Dependent, and Obsessive-Compulsive PDs (47; 49%), followed by "B"--Antisocial, Borderline, Histrionic, and Narcissistic PDs (21; 22%), and

"A"--Paranoid, Schizoid, and Schizotypal PDs (18; 19%). As in the aforementioned studies, the outcome following treatment for AI/PD patients, not to mention those AI/PD patients with two or more PDs, was poorer than the outcome following treatment for the AI/NPD patients. However, using multivariate analysis to evaluate the independent effect of each PD, this study found that cluster "A" PDs significantly worsened the treatment outcome for patients with major depression and a comorbid PD, x^2 $(1, N = 96) = 8.676$, $p = 0.003$.

Hardy et al. (1995) studied the treatment of depression with psychotherapy in depressed patients who were also diagnosed with a comorbid cluster "C" (Avoidant, Obsessive-Compulsive, or Dependent) PD diagnosis. They found that those patients diagnosed as severely depressed, per the Beck Depression Inventory (BDI) and the Symptom Checklist-90-Revised (SCL-90-R), did significantly worse on three of five treatment outcome measures (BDI average over treatment and follow-up, SCL-90-R average over treatment and follow-up, and the Present State Examination [PSE] average over treatment and follow-up) for depression treatment alone.

Shea et al. (1990) looked at the treatment of depression in patients with co-morbid PDs in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. This study involved 239 outpatient subjects. All of the subjects in this study met the criteria for a diagnosis of major depression, and 74% of the subjects in the study met the criteria for a diagnosis of major depression and at least one PD. All subjects were assigned to one of four 16-week treatment conditions. Shea et al. and Casey, Meagher, and Butler (1996) found that AI/PD patients had significantly worse outcomes following treatment, in the areas of social functioning and

residual symptoms of depression, than did the AI/NPD patients. With the exception of the AI/odd-eccentric PD patients, the AI/NPD and AI/PD treatment groups did not differ significantly in outcome on mean Hamilton depression scale scores, work functioning measures, or on the HSCL-90 depression scale. Although this finding may seem contradictory to the hypothesis of this paper, Shea et al. reported that, because the clearest outcome difference was on the Social Adjustment Scale, which was designed to tap more interpersonal feelings and behaviors (e.g., diminished contacts, reticence, friction, social discomfort, and loneliness), the importance of this measure in relation to PDs becomes clear; in this study, AI/PD patients' baseline level of social functioning is patterned with more significant maladjustment than AI/NPD patients. This research supports the hypothesis that brief psychotherapy for AI symptoms in AI/PD patients does not meet the psychologist's ethical and legal mandate to perform adequate treatment. Although AI symptoms may be reduced in the AI/PD patient, they usually do not decrease to the level of their AI/NPD counterparts and, more importantly, they often do not decrease enough to no longer meet the AI diagnosis they were treated for. Further, the gains achieved through brief treatment with AI/PD patients appear to rescind at a higher frequency than their AI/NPD treatment counterparts.

Researchers have found that the treatment of depression in the elderly is confounded by the presence of a comorbid PD as well. Thompson, Gallagher, and Czirr (1988) evaluated the effectiveness of brief psychotherapy on late-life (60 years old and above) depression with 120 patients. The subjects in this study were assessed for the presence of PDs on two levels: (a) their functioning during a depressive episode and (b) their functioning

during a nondepressive episode. The AI/PD patients in this study formed two distinct groups: those who appeared to have a constant PD and those who only met the criteria for a PD while experiencing a depressive episode. The study revealed that the AI/NPD patients were 4 times more successfully treated than those diagnosed as AI/PD. The authors contend that this finding was highly significant, x^2 (N = 120) = 5.025, p = .025, and that the significance of this finding was still apparent at a 6 month follow-up x^2 (N = 120) = 4.488, p = .034. This relationship was still evident at the 12 month follow-up; however, the significance of this finding was lost because of a small increase in the number of AI/PD patients who no longer met the study's criteria of having a definite or probable diagnosis of Major Depressive Disorder. For those patients who only met the criteria for a PD during a depressive episode, their successful treatment for depression was more favorable than those patients who reported having a constant PD (Post treatment, 89% vs. 41%, significant; 12-month follow-up, 83% vs. 51%, nonsignificant). Nevertheless, the presence of a PD was still significant in relation to the outcome of treatment, x^2 (N = 120) = 4.274, p = .039; the AI/NPD patients had approximately an 8 times greater success rate in the treatment of their depression than did their AI/PD (only during a depressive episode) counterparts. The authors conclude that elderly patients with PDs and depression are less likely to benefit from short-term psychotherapy than elderly patients who only meet the criteria for depression.

Psychotherapy Benefits

As stated in the introduction, this section will offer research that supports the many different benefits of psychotherapy. Specific to the treatment of PDs, research will be offered which indicates the lasting

treatment effects of long-term therapy. An alternative means of deciding which patients are compatible or noncompatible with managed care psychotherapy will also be offered in this section. This alternative way of describing a patient's and therapist's goal for therapy, symptom reduction or trait change, is supported through treatment outcome research and may be more encompassing and less pathologizing than using the aforementioned DSM-IV criteria of PDs. Finally, it should be noted that portions of this section were adapted from Sorenson's (1998) article, "Is Psychotherapy Dead?" and Ackley's (1997) book, Breaking Free of Managed Care.

Psychotherapy is effective in helping people. Research supports this statement as many articles point to its effectiveness. Although Hans Eysenck's (1952) review of the literature claimed that those who were on a wait list for therapy improved as much as those who were in therapy, this finding was refuted when his data was reanalyzed; the very same studies Eysenck used in his literature review, when errors were corrected and different classifications of outcomes were used, actually supported the effectiveness of psychotherapy (Bergin, 1971). More striking is Smith, Glass, and Miller's (1980) psychotherapy outcome study in which a meta-analysis of 475 studies, which included 40,000 subjects in control groups, was performed. Although this study was carefully designed to analyze the previous 475 studies in a way that did not distort or misrepresent the findings, its results were extremely positive. The study showed that patients who received psychotherapy improved almost a full standard deviation above those who did not receive psychotherapy.

Diagnosis and Treatment Considerations

The DSM-IV (American Psychiatric Association,1994) defines a PD as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 629). Oldham (1992) stated that "a consensus has evolved [in the mental health field] to describe personality as a combination of temperament and character; temperament referring to constitutional and genetic factors and character referring to the personality attributes produced by experiences and life events" (pp. 414-415). He further stated that "There has been an increasingly clear consensus that most types of psychopathology have both genetic and environmental origins, in varying percentages" (p. 418). However, within the field of clinical psychology there is debate over the concepts of personality and PDs. Rather than engaging in a debate beyond the scope of this paper, some ideas of personality and PDs on which clinical psychologists, for the most part, agree will be presented.

So far this paper has relied on formal DSM-IV diagnostic categories (AI and PDs) to discuss which patients should or should not receive brief, symptom-focused psychotherapy (managed care psychotherapy). Another way that clinicians differentiate patients between short-term and long-term therapy, which may have an inherent benefit of valuing the patients' opinion regarding the type of therapy (short- or long-term) they want to receive, is to assess if treatment will entail symptom improvement or trait change (Ackley, 1997). Steenbarger (1994) did a meta-analysis of therapy outcome studies and found that researchers define the psychological improvements which occur in therapy in one of two ways: symptom

improvement or trait change. In the studies he reviewed, Steenbarger found that symptom change is relatively easy to attain whereas trait change takes time. As Ackley (1997) stated, "If the definition of 'improvement' is a matter of symptoms, short-term therapy looks pretty good. For people looking to make more basic changes in themselves, perhaps to ward off the likelihood of having another bout of symptoms, brief therapy does not do as well as longer-term therapy. More time in therapy is required to change traits than managed care usually allows" (p. 16). Further, "If someone has spent a lifetime building a personality pattern, changing the pattern itself takes more time than countering the latest instances of symptomatic behavior" (p. 16).

Applying what Steenbarger (1994) discovered in his meta-analysis study to the treatment of PDs, a fairly safe observation can be made: DSM-IV diagnosed PD patients are those who will be helped by trait change. PD patients often exhibit and/or report more psychological difficulties than NPD trait change patients and can be more resistant to change. Since research indicates that patients entering therapy for trait change require long-term rather than short-term therapy, then only considering the confounding effects of PDs on AI treatment may be a truncated approach in evaluating which patients are appropriate or inappropriate for managed care psychotherapy. One implication that can be drawn from Steenbarger's (1994) findings is that patients who exhibit strong traits of a PD should also be considered incompatible with managed care psychotherapy. These patients would include those who are one or two symptoms short of a full PD diagnosis and/or patients whose psychological discomfort is rooted in a longstanding personality pattern which will take more time to treat in therapy than countering the latest instances of symptomatic behavior

(Ackley, 1997).

Long- Versus Short-term Psychotherapy

The ability to effectively treat PDs is supported throughout clinical psychology's literature. However, Oldham (1992) reported, literature on the empirical study of the treatment of PDs is lacking. Oldham explained that this has happened because of the inherent difficulty in empirically studying long-term treatment modalities. He stated that a false illusion has been created concerning the superiority of brief psychotherapies over long-term therapies. Even though clinical psychology does not have as much empirical data on long-term psychotherapy as it does on brief therapy, the assumption that brief therapy is more efficacious should not be made. Studies will be cited below which point to the different strengths and weaknesses of both long-term and short-term therapy. Further, and more specific to the purpose of this paper, studies will be cited which point to the effectiveness of treating PDs and trait change.

Long-term treatment is a common denominator among all psychotherapy approaches to trait change or PDs. Oldham (1992) stated that "personality disorders have been viewed as indications for long-term, psycho-dynamically-oriented psychotherapy or psychoanalysis" (p. 421). Although this statement excludes other treatment modalities which have been successful in the treatment of PDs, Oldham's emphasis is that trait change issues or PDs take time to treat. Stevenson and Meares (1992) studied 30 patients diagnosed with Borderline PD (BPD). All patients were treated with a self psychology approach for 12 months, two times a week in an outpatient setting. Results demonstrated statistically significant improvements on all assessment measures. At the end of their treatment

phase, 30% of the patients no longer fit the DSM-III criteria for BPD. This is a positive finding in regard to the treatment of PDs. This finding is staggering, however, when considering that many patients with PDs receive only managed care psychotherapy. If only 30% of the patients in the aforementioned study no longer fit the diagnosis of BPD after 1 year of multiple weekly therapy sessions, lasting benefits cannot be expected with 6 or 7 managed care therapy sessions for these same patients.

The choice of short term treatment should be contingent upon the presentation of the patient. If "the research shows that time limited treatment is inferior to psychotherapy in which the treatment time is clinically determined" (Miller, 1996, p. 567), then psychotherapists need to be cautious in their use of short-term psychotherapy. The danger in subjecting a patient who needs long-term therapy to managed care treatment is "that time limits merely curtail treatment before optimal benefits are achieved, and for some clients, before psychologically necessary gains are accomplished" (Miller, 1996, p. 567).

In the treatment of anxiety, David Barlow (1991), a top researcher in anxiety disorders, has reported that patients with simple panic disorders show marked signs of improvement in about 8 to 12 sessions of psychotherapy. However, patients who present with a panic disorder and contextual or related issues, which is more common, need significantly more therapy to achieve lasting treatment results. Steenbarger's (1994) study supports Bartlow's report. Steenbarger's findings show that managed care psychotherapy is more effective in reducing symptom-oriented changes, whereas long-term, psychodynamic psychotherapies are more effective in instigating trait or personality changes. As Ackley (1997) stated,

> This observation makes clinical common sense. Brief therapy is designed to treat symptoms - hence, it is not too surprising that it does a better job. Conversely, dynamically oriented therapy is oriented to more fundamental aspects of personality, and thus it is not surprising that it does a better job with them. The research shows that schools of therapy do what they are intended to do. (p. 17)

As for the effectiveness of long-term psychotherapy, a very influential and compelling study was done with actual consumers of psychotherapy. Consumer Reports ("Mental Health,"1995) did a study of real people and their experience of outpatient psychotherapy entitled, "Mental Health: Does Therapy Help?" Consumer Reports consulted with the former director of training in clinical psychology at the University of Pennsylvania, Martin Seligman, in constructing the survey and interpreting the survey's results. In short, of the 4,000 readers who responded, 90% reported that when they entered therapy they felt "very poor," and therapy either helped them "a lot" (54%) or "somewhat" (36%). These are positive findings. However, the relationship between the duration of treatment and the degree of help received appears even more impressive. Fifty percent of patients who stayed in therapy for more than 6 months reported that therapy helped a lot, whereas 33% of patients who stayed in therapy for 6 months or less reported that therapy helped "somewhat." Seligman (1995) concluded "that patients benefited very substantially from psychotherapy, that long-term treatment did considerably better than short-term treatment, and that psychotherapy alone did not differ in effectiveness from medication plus psychotherapy" (p. 965).

Finally, Steenbarger's (1994) meta-analysis of therapy outcome study also revealed five therapy duration/outcome variables which may be used as a "decision tree" in regards to the course of therapy. More specifically, these variables can be used as a benchmark for deciding which patients can or cannot be adequately treated by managed care psychotherapy. However, once these three variables are examined, it becomes apparent that a thorough intake--much more thorough than the HCS deems as necessary--is needed in order to assess patients for the positive or negative aspects these variables identify. Further, the last two variables allude to the advantages of long-term psychotherapy over short-term, managed care psychotherapy. These five variables are discussed below.

1. "Clients who enter therapy with strong interpersonal skills achieve results faster than clients whose interpersonal skills are weak" (Ackley, 1997, p. 17). Steenbarger's (1994) study indicates that patients with anxiety and depression exhibited less psychological discomfort with 8 to 13 sessions, whereas patients with Borderline PD (BPD) showed similar psychological benefits with 26 to 52 sessions. Ackley noted that patients whose interpersonal skills are lacking, such as in the BPD patient, need much more time for a therapeutic alliance to form before they begin progressing in therapy.

2. "Clients actively involved in therapy change faster than those who take a more passive approach" (Ackley, 1997, p. 17). Steenbarger (1994) defined actively involved patients as those who are both emotionally activated in session and who do their homework outside of session. Ackley commented that therapists must become sensitive to the fact that psychological change in patients happens at different rates (i.e., the issue of

resistance in therapy). Hence, as Miller's (1996) study indicated, a patient's presentation should dictate the type of therapy and treatment plan that will be most beneficial to them, not the other way around.

3. "When presenting problems are clearly defined, it takes less time in therapy to achieve the desired result. When the presenting problems are complex or vague, therapy takes longer to achieve positive outcomes" (Ackley, 1997, p. 18). The value of a thorough intake becomes extremely evident in this variable.

4. "Therapeutic gains can be lost posttreatment when contextual issues are not considered" (Ackley, 1997, p. 18). Ackley stated "This, of course, supports the long tradition therapists have had of attending to related issues, along with the presenting problem. Therapists are not just keeping people in therapy for their own self-enrichment. They are cementing treatment gains. The research bears out our clinical judgment" (p. 18).

5. "As many as 78% of short-term therapy clients who are then maintained by medication alone relapse. Their symptoms come back" (Ackley, 1997, p. 18). Sadly, this is the standard treatment protocol often endorsed by managed care. Ackley accurately observed that managed care may achieve short-term benefits with this approach, but not lasting ones.

Related Health Issues and Medical Costs

There are numerous studies supporting the theory that psychotherapy reduces overall medical costs, including the cost of psychotherapy, for medically ill patients (Borus et al., 1985; Brody, 1980; Fiedler & Wright, 1989; Gonik et al., 1981; Jones, 1979; Kessler, Steinwachs, & Hankin, 1982; Massad, West, & Friedman, 1990; Mumford, Schlesinger, Glass, Patrick, & Cuerdon, 1984; Schlesinger, Mumford, & Gene,1983). Mumford et al.'s (1984) review

included data from 58 other studies on the cost effectiveness of including psychotherapy as part of medical treatment. When psychotherapy was included, the utilization of overall medical services was reduced between 10% and 33%. These results suggest that many reported physical ailments are either psychological in nature or are exacerbated by psychological discomfort and, further, that patients may report, consciously or unconsciously, their psychological pain in the form of physical illness. Sheehan, Ballenger, and Jacobsen (1980) found this to be true in their study. They found that 70% of people diagnosed with panic disorder saw 10 or more medical doctors before they received appropriate mental health treatment. Similar findings in other studies (Brody, 1980; Kessler, Cleary, & Burke, 1985; Orleans, George, Houpt, & Brudie, 1985) indicate that 25% to 70% of the patients seen by general practitioners are reporting psychological discomfort as physical ailments.

Many patients who report psychological distress to their general practitioners are treated for their symptoms by their general practitioners. An article in the summer 1995 issue of Advance entitled "Did you know?" reported that 46% of psychotherapy is given by general practitioners. Seventy-one percent of these practitioners reported inadequate time to address their patients' concerns while 32% reported inadequate training/knowledge in treating psychological disorders. Further findings indicate that 83% of those who seek out their general practitioners for psychological discomfort receive medication and little, if any, psychotherapy ("Mental Health," 1995; Seligman, 1995). If this last finding is true, then, when compared with Steenbarger's (1994) findings, there should be a great concern for the overall level of patient care in this country. Steenbarger's findings indicated that up to 78% of patients who are maintained by

medication alone, after receiving brief psychotherapy, have their symptoms come back. Therefore, if general practitioners see 83% of the patient population that complains of psychological discomfort, mainly prescribing medications and offering little or no psychotherapy, then it is very likely that more than 78% of patients who do not receive psychotherapy experience a relapse of symptoms.

Section Two: Implications of Research

The second section of this paper will be a discussion. Implications from the first section's findings will be used to discuss the status of clinical psychology's relationship with the HCS. Three perspectives on this relationship will be offered. An important focus of this section is the observation that clinical psychologists are not powerless against managed care and have the ability to make choices regarding the nature and scope of their practices, including the nature of their relationships with their patients and the HCS alike.

Expanded Relationship

One direction the relationship between psychology and the HCS could go is expansion. If the HCS were to expand its relationship with clinical psychology it would do so for one reason only: cost effectiveness. Although research has shown that psychotherapy is cost effective over time (Mumford et al., 1984), profit over time does not appear to be a primary interest of HCS agencies. Therefore, any attempt to influence the HCS into expanding its relationship with clinical psychology (i.e., covering all necessary costs of psychological treatment) will most likely fail. Psychologists who desire an expanded relationship believe that psychotherapy is too expensive for their

patients to pay out-of-pocket and, therefore, see their current relationship with the HCS as too constricted. Many psychologists believe that if the HCS were to expand its relationship with clinical psychology, psychologists' practices, as well as their pocketbooks, would be full once again. Further, if the relationship between the HCS and clinical psychology were to expand (i.e., the HCS paid psychotherapists to see patients as long as needed), then psychotherapists would be able to treat patients in a health-conscious, ethical, and legal manner.

Constricted Relationship

The second direction that the relationship between clinical psychology and the HCS could go is constriction. In this relationship the HCS would only pay for inpatient and crisis intervention situations. The HCS's motivation for doing so would be the same as all of its past decisions: cost effectiveness. Further, another reason why psychologists may face a constricted relationship with the HCS is because of the HCS's failure to survive. The HCS itself can be an unstable industry with constant bankruptcies, mergers, and lawsuits. A recent example (March, 1999) is the bankruptcy of MedPartners, a company that managed Talbert Medical Group, Mullikin Medical Group, and Friendly Hills Medical Group. Thus, clinical psychologists may face a constricted relationship with the HCS because of the end of the HCS. However, a growing number of clinical psychologists have already taken control of their practices by primarily seeing, or only seeing, patients who pay for their services out-of-pocket.

Before discussing the various reasons why therapists have chosen not to work with third party paying patients, it is important to look at how the HCS's reimbursement of psychological services creates limitations for clinical

psychologists, as well as the people they serve. More specifically, as proposed in the introduction of this paper, the current relationship between clinical psychology and the HCS may only be adequate for the treatment of simple Axis I disorders.

The Altered Perception of Psychotherapy

One way to consider the limitations which have arisen through third party payment is by asking a question: Can't third party payment for psychotherapy be simply understood as a bonus to one's medical insurance? The question implies that the client and therapist alike should be grateful for any reimbursement from an insurance company for psychotherapy. If one accepts this implication then he/she would have no qualms about what psychological services insurance companies do or do not pay for. Further, if one accepts, or has come to accept this inference, he/she may see any questioning of the relationship between clinical psychology and the HCS as misinformed scapegoating. However, the HCS, by offering limited, brief psychotherapy, may have altered the way patients perceive or understand the nature of psychotherapy.

More importantly, the HCS has possibly altered how clinical psychologists view psychotherapy and the treatment of psychopathology. For patients and therapists alike, psychotherapy, and the treatment of psychopathology, has become what the HCS offers as psychological treatment. There are two possible issues inherent in this mind set: money and trust. Those with insurance have a mind set to only seek psychotherapy that is covered by their insurance provider. Further, patients trust that what their insurance provider offers them for treatment will be adequate to alleviate them from their psychological discomfort. They may conclude that it would

be a waste of time, energy, and money to pay for (more) psychotherapy. For example, patients might need (or feel the need for) individual psychotherapy, and yet their insurance provider will only offer them hospital-based group therapy with a master's level therapist, or an R.N. The patient accepts this because (a) this is what they've been offered by their insurance company, and (b) they assume that their insurance company must at least provide them with adequate treatment.

Another possible altered perception, in regards to the efficacy of psychotherapy, may occur in patients who have already sought psychotherapy through their insurance provider. If a person believes that adequate treatment will be provided for their psychological discomfort and then finds little or short-lived helpfulness from the psychotherapy the insurance company provides, that person is not likely to pursue further or future treatment. Thus, through the process of receiving inadequate psychotherapy with their first therapist, patients may become disillusioned about the benefits of good psychotherapy because therapy didn't work for them the first time; ignorance about what good psychotherapy can do for people may be exacerbated by the psychotherapy the HCS dictates.

There are two possible issues that arise when patients are treated with brief psychotherapy when longer-term psychotherapy is indicated: treatment's results at termination and its lasting benefit in the months and years that follow. For example, the empirical studies reviewed in this paper suggest that both of these issues are salient in the brief treatment of the AI/PD patient. When AI treatment is complicated by the presence of a PD or trait change issues, the aforementioned problems can disrupt a patients' trust in what psychotherapy can do for them and, further, the ramifications of

inadequate psychotherapy can become a significant ethical issue for the therapist involved.

It's understandable that people would want to save money, but saving money is not the only possible reason why more people do not seek out long-term therapy. When the HCS pays for time-limited psychotherapy, what it offers (or fails to offer) may be dangerous. To only offer limited, brief psychotherapy may alter how people perceive psychological treatment so that it prevents them from seeking the help they know they need.

As stated above, the current relationship between clinical psychology and the HCS may have influenced how mental health professionals view psychotherapy. Rather than working towards health, it appears that many psychotherapists may now work towards the reduction of symptoms. Is this psychotherapy now? Perhaps a paradigm shift has occurred in some psychologists, especially for those who work within the managed care system, not so much in their theories of psychopathology but in their assumptions about what constitutes adequate treatment of psychopathology. It seems that rather than psychotherapy beginning with an agreement between therapist and patient to have an end goal of healthy functioning, managed care psychotherapists have adjusted their goals to doing what can be done in six or seven sessions. As Ackley (1997) reported regarding his initial meeting with a provider panel for a managed care company, "These people seriously expected episodes of care to run about six sessions" (p. 4). Further, this paradigm shift seems to be the prevalent model in some graduate programs and psychotherapy training sites and, therefore, may be distorting what constitutes adequate treatment for beginning psychotherapists.

Sorenson (1998) addressed the current status of psychotherapy in an

article entitled, "Is Psychotherapy Dead?" He proposed an analogy between Nietzsche's death of God with the perceived death of psychotherapy. As Sorenson noted, Nietzsche was not claiming that God ever actually existed, but rather that God, like all concepts, is a social construction, and God "died" when humanity no longer believed in him as a "plausible reality" (p. 111). Similarly, many psychotherapists have stopped believing in non-managed care psychotherapy as a "plausible reality." According to Sorenson (1998), "We who are psychotherapists would do well to periodically ask ourselves, is psychotherapy a part of the health profession? How we answer that question has a lot to do with whether psychotherapy as a profession will be alive for us or dead" (p. 112). What Sorenson leads us to is the idea that, if we view ourselves as part of the health profession, we may be in serious trouble. As Ackley (1997) stated, "Professional organizations tell us to get with the managed care program or plan to park cars for a living. Managed care then tells us that it can use only about one-third of the therapists currently in practice" (p. 1). Therefore, psychologists may need to view themselves as providing a unique service to society, not as part of medical field or the medical managed care system.

Psychotherapy Outside of the HCS

Psychotherapy outside of the HCS appears to be beneficial for both therapist and patient. When therapy is paid for out-of-pocket, issues of informed consent (confidentiality, payment, and termination) and the overall course of therapy are in hands of those who matter: the therapist and the patient. There are also other issues, with therapeutic implications, that stem from how the therapist and patient view the issue of payment. This section will discuss some of these underlying issues which lead both

therapist and patient to pursue non-managed care psychotherapy.

The theory or model in which a therapist approaches psychotherapy also has a dramatic impact on the course and outcome of therapy. Psychologists accept the medical model's philosophy of treatment, consciously or unconsciously, when they engage in a therapeutic relationship with a third-party paying patient. Sorenson (1998) stated that the health profession has a "diagnose-treat-and-cure model to human suffering. The aim of health professions is remedial: to return to premorbid levels of functioning" (p. 114). This goal of the HCS has affected managed care psychotherapy by making the reduction of symptoms its focus. In regards to Steenbarger's (1994) findings, the HCS has taken the more conservative definition of improvement, symptom reduction, and applied it to their measure of "medical necessity" (Ackley, 1997), therefore making symptom reduction the only goal for managed care psychological treatment. Again, this is psychotherapy in the HCS.

Psychologists before the era of managed care did not take a diagnose-treat-and-cure approach to treatment. Thus, their focus was not primarily on the absence of negative symptoms. This is evident when psychology's theories and treatment of psychopathology, before the era of managed care, are considered. Even the current theories of brief treatment accurately acknowledge that trait change issues are disruptive to the brief treatment process. In the world of managed care psychotherapy, these treatment models, in their most rigid form (six to seven sessions), are being imposed upon patients who have trait change issues. More disturbing, this type of managed care psychotherapy is being taught as adequate treatment and standard practice in many graduate psychology schools across the country.

A model that some psychologists use is what Sorenson (1998) has called a developmental model. Sorenson explained that this type of treatment is about working towards health. He offered other words or phrases to describe this model's intent, "such as optimal well being, a preferred future, an intentional lifestyle, [or] an abundant life" (p. 115). In the spirit of addiction treatment, the developmental model is about accepting what one cannot change, yet working towards changing what one can--and the wisdom to know the difference. When the research on AI/PD patients and trait change is considered, this approach to treatment becomes more than valid; it is absolutely necessary for any psychological treatment that involves or requires trait change.

It is obvious, from the research offered as well as from clinical judgment, that this type of psychological treatment takes time. Regarding the issue of time, when comparing the developmental and remedial model, Sorenson (1998) made an interesting point. He stated that the medical field, with their diagnose-treat-and-cure approach, looks at longer treatment time as a failure. However, the developmental model's approach to the issue of time is much different. Sorenson pointed out that that in other fields or disciplines, people embrace the inherent issue of time in the developmental model. Education is one of these areas. People continue in education because it works for them: the best students go on to graduate school. Religion is another entity which embraces the developmental model: people stay involved in religion because the more they participate, the more it helps them. Finally, in defense of a developmental model for psychotherapy, people continue in their therapy not because it isn't working, but because it is.

Another factor which may influence a patient to pay for psychotherapy out-of-pocket is how the issue of payment affects them emotionally. When examining third party payment and how the therapist's and the patient's entire relationship hinges on someone's opinion other than their own, feelings of helplessness almost automatically surface. Sorenson (1998) asked appropriately "What causes psychopathology in the first place [?]" (p. 113). He goes on to say that many theories of psychopathology point to "one person, who is in a position of less power, having to depend on another person or group, who is in power, and who uses the first person as a means to an end rather than an end in his or her own right" (p. 113). In managed care psychotherapy, both the therapist and patient are under the control of the HCS once they engage in a therapeutic relationship. If psychologists allow themselves to engage in a helpless relationship, which appears inevitable when working under the HCS, what are they modeling to their patients? Sorenson stated, "As I see it, participation in the system I have just mentioned is an exercise in a form of learned helplessness, for both the client and the therapist, and is itself a recapitulation of a pathogenically traumatic relationship. Ironically, while we seek to alleviate human suffering, some of our patterns of reimbursement run the risk of unwittingly perpetuating and retraumatizing people with the very problems we sought to lessen" (p. 114).

Psychotherapy that is paid for out-of-pocket can remove feelings of helplessness from therapy and replace in the patient a sense of empowerment and responsibility for their own lives and well being. This thinking is in line with most of the theories of change in psychology. As Ackley (1997) stated,

Can you name one [psychology treatment theory] that does not

> encourage clients to take responsibility for their behavior? Each, in its own way, searches for ways to empower people so they can respond to the world more effectively and gain greater control over themselves. These models demand acceptance of personal responsibility regardless of how one came to be in a particular set of circumstances. (p. 51)

Thus, on one hand, a patient's reliance on the HCS to cover the cost of their psychotherapy may perpetuate their sense of being an ill, helpless victim. On the other hand, paying for therapy out-of-pocket may instill a sense of empowerment, showing patients that they are able to help themselves and take control of their lives. Regarding counseling prospective patients about their managed care or out-of-pocket therapy options, Sorenson (1998) stated "The point is that 'health'--or, as I prefer, maturity, or optimal well being, or wisdom--has to do with taking responsibility for choices we may not have known were open to us" (p. 119). Thus, patient's need to know our beliefs surrounding managed care so they can begin to understand their options in this matter.

One final area of concern in the constricted relationship is "Can patients afford to pay for psychotherapy out-of-pocket?" Sorenson (1998) and Ackley (1997), both psychologists whose practices are primarily managed care free (Sorenson's is completely), agree that it is possible to maintain non-managed care practices. They further agree that patients can afford to pay for services out-of-pocket, and they will pay for our services out-of-pocket as long as the services psychologists offer are seen as something of value. People already pay an extraordinary amount of money for out-of-pocket health care services. Ackley noted that while $800 billion was spent on

traditional health care services in 1992, $114 billion was spent on out-of-pocket health care services in that same year. This indicates that people value health and that they are looking beyond managed care to find it. People purchase what they value, and people value the feeling of health and well being. Psychologists are experts in guiding people towards this.

The issue of cost does not seem to influence people as much as the issue of value. As Ackley (1997) observed, "As they see new areas of value, people reorganize their spending priorities. There was a time, not long ago, when people did not make room in their budgets for cellular telephones, VCRs or computers. They do now" (p. 42). Therefore, maybe people need to sense the real value of psychotherapy. As Sorenson (1998) stated, "People have fecal detectors that intuitively sniff out any lack of congruence. As a result, we tend to get practices in our own image. If we've not known the transformative power of exquisite psychotherapy in our own lives, how often might we end up attracting people who feel the same about what we have to offer them" (p. 119)? Finally, Ackley wisely observed

> We convinced ourselves that only rich people could possibly afford to pay us out of pocket. What does this say about the value we saw in our work? People will not and should not believe in the value of therapy services if therapists do not. With apologies to the movie Field of Dreams, if you value it, they will come. If you do not value therapy enough to charge a rate that speaks to its value, they should not come. (p. 42)

Status Quo Relationship

The third direction entails maintaining the status quo. The current relationship between psychotherapists and the HCS is the HCS's design. It believes it is in control of the relationship between itself and clinical psychology and, for the most part, clinical psychologists believe this to be true. Most psychologists believe that the current relationship with the HCS is all we have to work with; this is clinical psychology now.

Those who choose to work with patients whose full or partial payment will be coming from the HCS need to take measures to protect their patient's rights and well being, as well as measures to protect themselves from violating their ethical and legal obligations. With the specific example of AI/PD patients, is it possible for therapists to ensure adequate treatment of these patients, without abandoning them, should payment from the patient's insurance provider cease before treatment is completed? A hard truth to accept for psychologists who choose to work within the HCS is that the relationship between clinical psychology and the HCS is not moving towards expansion. Therefore, they need to accept the relationship for what it is and, in doing so, always strive to work in a legal and ethical manner.

This section of this paper addresses many legal and ethical issues specific to third party payment--many issues that psychologists need to consider before engaging in such a relationship. Because the length of treatment in managed care psychotherapy is decided by the insurance provider, not by the therapist or patient, a way of implementing the various stages of informed consent is proposed that is beneficial to both therapist and patient. These issues, if not dealt with properly, could have a detrimental effect on both patient and therapist. Before discussing all of these issues one

at a time, however, the foundation for them all is informed consent.

Pretreatment Considerations

The first pretreatment consideration within the status quo relationship is integrity. When interacting with the HCS, the first and foremost issue for psychologists is integrity. Because the current relationship between clinical psychology and the HCS is adversarial (Sanders, 1998), honesty and integrity with reviewers and in treatment plans have become synonymous with economic murder. Sanders (1998) stated that psychologists must "deal with it [the relationship between clinical psychology and the HCS] cooperatively where possible, assertively where needed, and ethically always" (p. 103). If a psychologist agrees to see a third-party paying patient, then the psychologist must provide the HCS with the information reviewers routinely ask. Polonsky (1993) stated that what reviewers want from the psychologist, at minimum, is the patient's symptoms, a diagnosis, and the therapist's treatment plan, which should reflect a resolution of the patient's stated symptoms.

Psychologists, in the area of reimbursement for psychological services, must maintain integrity and honesty in what they report to a patient's insurance provider (psychologists' responsibility in this area is found in their ethics code, Ethical Standard 1.26; American Psychological Association, 1992). Psychotherapists need to diagnose correctly, even if this means fewer, little, or no sessions with a patient. They need to report that they are seeing a patient in individual therapy when they are seeing the patient individually, and that they are doing couples therapy when they are seeing a couple. Psychotherapists need to inform insurance companies the exact amount their patient is paying in the instance of split payment--not a different amount.

Dishonesty in these areas and others may lead to legal action against the therapist, hurt the name of the profession, and, worse yet, decrease the chances that the patient will ever be helped through the means of psychotherapy. This is true even if the psychologist and patient are not caught in their dishonesty with the patient's insurance company. At some level, all therapists would agree that psychotherapy is about honesty. If every aspect of therapy, down to reimbursement for services, is not dealt with in an open and honest manner, how will therapy be of any benefit to those it serves?

The second pretreatment consideration within the status quo relationship is diagnosis. Another issue that deserves thought before any therapist engages in a therapeutic relationship with a patient, especially brief treatment with a third-party paying patient, is that of diagnosis. Research supports the theory that the treatment of AI disorders is confounded by the presence of a comorbid PD. Therefore, to avoid ethical and legal issues surrounding inadequate treatment and client abandonment, several principles apply. The therapeutic relationship should begin (a) only after a thorough intake has been done and (b) only when a clear diagnosis of a simple AI disorder has been made. The only exception to working with patients who have a diagnosis other than a simple AI disorder is if the patient's insurance provider agrees with the psychologist's treatment plan (i.e., 6 months of therapy, 1x a week; 1 year of therapy, 2x a week; etc.). If the need for longer-term psychotherapy becomes apparent after therapy has begun, managed care psychotherapy (symptom reduction) will most likely be nonbeneficial to the patient. This, in turn, may create an ethical and legal issue regarding inadequate treatment (and client abandonment if the

therapist were to abruptly terminate therapy at the end of payment).

The third pretreatment consideration within the status quo relationship is the initial intake session(s) in regard to informed consent. Many psychologists who work with managed care are reluctant to do lengthy intake assessments with their patients because they are "on the clock" with the insurance company the moment the patient steps into their office. Thus, the six to seven sessions they are receiving from the insurance provider begins with the first session. However, going over confidentiality, informed consent, then briefly screening a patient before introducing them to a short-term model (which has become the norm in managed care psychotherapy) is an inadequate intake process.

For ethical and legal reasons, it is imperative that patients sign confidentiality and payment/office policy agreements before they enter the therapist's office (e.g., patients can sign these documents in the waiting room). Once a patient is in the therapist's office, these same documents need to be discussed thoroughly to ensure that the patient clearly understands what has been signed. The reason why this is imperative is because the therapeutic/professional relationship begins the moment a patient enters a therapist's office. What is discussed and signed regarding informed consent should include confidentiality, payment agreements/office policies, and termination.

Because of a psychologist's ethical mandate to perform adequate treatment, psychologists should gain an adequate history and diagnosis of their patient before engaging in managed care psychotherapy, even if it means not being paid for the time it takes to do so. This is part of the psychologist's ethical mandate to perform adequate treatment. Six or seven

sessions with a patient is the minimum number needed to treat most simple AI disorders. If therapists do not take the time to adequately diagnose their patients before engaging in therapy and then find that their patients cannot be adequately treated within the HCS allotted time frame, they may be left facing the ethical dilemma of client abandonment. It is clearly stated in the American Psychological Association's (1992) Ethical Principles of Psychologists and Code of Conduct, in Ethical Standard 4.08., that the onus for an adequate resolution of therapy is on the therapist. Psychologists can be held liable for client abandonment if they terminate therapy prematurely because of the financial limitations of the patient.

In their commentary on Ethical Standard 4.08, Canter, Bennett, Jones, and Nagy (1994) stated "Psychologists should be aware that several courts have ruled in effect that when a physician makes a decision to discharge a patient because an insurance company refuses to pay benefits, both the physician and the insurer can be held liable if their conduct was a 'substantial factor in bringing about the harm' (Wickline v. California, 1986; Wilson v. Blue Cross, 1990)" (p. 99).

The therapist, before meeting with the patient face-to-face, would need to receive a verbal release of information from the patient to contact the patient's insurance provider (which the therapist would document and have the patient sign at their first meeting), gaining permission for the initial intake assessment. Permission from the patient's insurance provider is needed because the insurance provider could count the intake assessment session(s) as previous treatment, therefore shortening the number of sessions remaining for the patient.

If permission is granted, in the first meeting with the patient the

therapist should discuss what will happen during the next session(s) regarding documenting the patient's history, diagnosing the patient, and creating a treatment plan. Following the intake assessment, a decision needs to be made whether or not a brief therapeutic relationship will begin. This decision, of course, is made by both the therapist and patient.

Therapists should make their decision to engage in a brief therapeutic relationship only if they believe the patient will be adequately treated within the HCS's allotted time frame. If a patient informs a therapist that he or she is only interested in receiving therapy that is covered by his of her insurance provider and the therapist has gained a history and diagnosis that is not conducive to brief therapy, then, according to ethical principles, the patient and insurance provider should be informed that the therapist will be unable to work with him or her under brief therapy conditions. Once the patient is informed of this, and if the patient is adamant about not paying for possible additional out-of-pocket sessions, the therapist then needs to make the necessary referrals and kindly send the patient on his or her way.

If a therapist does not receive permission from the patient's insurance provider for intake assessment session(s), the therapist may need to refer the patient to another therapist. The exception to this would be if the patient's insurance provider offered more than 10 sessions without exception. Even if the initial intake assessment took 2 sessions, the 8+ remaining sessions should be adequate time to treat most simple AI disorders. If the patient could not be treated in the remaining 8+ sessions, the patient and the insurance provider would need to be informed of this. If the insurance provider is unwilling to pay for services according to the therapist's treatment plan and the patient is unwilling to pay for service out-of-pocket,

then, again, appropriate referrals must be made.

In summary, therapists who work with third-party paying patients run the risk of entering into therapy with patients who cannot be adequately treated within the allotted time frame for which the insurance provider is paying. Thus, therapists who work with third-party paying patients must make careful initial diagnoses or run the risk of either client abandonment or working longer with the patient (possibly long term--paid for by the patient) for a reduced fee or for gratis. Initial intake/assessment sessions prearranged with the HCS seem essential for ethical practice.

Informed Consent for Managed Care Treatment

The first issue of informed concent for therapists who engage in managed care treatment is conflict of interest in regard to confidentiality. Confidentiality is an issue which becomes more complicated when working with a third-party paying patient. The change in confidentiality that occurs between third-party paying and out-of-pocket paying patients is striking. The core difference lies in the issue of divided loyalties (Sanders, 1998).

Sanders (1998) pointed out that psychologists have an obligation to the patient to provide him or her with the best care possible, as well as an agreement with the patient's insurance company to limit costs of services. Thus, consciously or unconsciously, a portion of a therapist's loyalty is surrendered when he or she accepts third-party payment for the psychotherapy he or she provides. Further, their loyalty will inevitably be tested through an ongoing conflict of interest: the psychologist's interest for his or her patient's safety, health, and wellbeing, versus the HCS's interest in cost containment. For example, as Sanders observed, what if a psychologist believes that his or her hospitalized patient is still actively suicidal, but the

patient's insurance provider believes that the degree of risk in the patient does not justify the hospitalization cost? In this situation the psychologist is in a dilemma, one with legal and ethical ramifications.

As Sanders (1998) stated, "Managed care ushers in an era when as never before, people other than the therapist will know confidential details of patients' backgrounds" (p. 105). Psychologists should strive to maintain their patients' confidentiality at all cost. Because of this, an admonition for therapists to always strive for integrity when working with third-party reimbursement is essential: Give the insurance company the information it needs, but at bare minimum. This is because neither the therapist nor the patient has control over the patient's personal information once it is given to the insurance provider. Sanders made the point that "Therapists have a responsibility to judge carefully the managed care company's need to know when completing treatment reports" (p. 106). Sanders also called therapists to be assertive (not passive, aggressive, or passive-aggressive) when dealing with insurance companies by questioning any information a reviewer asks for that is not pertinent to the case at hand. Obviously, therapists need to have their patients sign release forms for any information they relinquish to the patients' insurance companies and must inform their patients of the ramifications of doing so (Sanders, 1998).

The second issue of informed concent for therapists who engage in managed care treatment is payment. Payment for services with third-party paying patients has obvious drawbacks when compared to payment from out-of-pocket paying patients. Out-of-pocket paying patients either can or cannot make payment for the services they've received. And, if the patient cannot pay, the therapist has direct contact with the payment source to

discuss the situation and its remedy. However, with third-party paying patients, all aspects of payment, in reality, are established and controlled by the HCS. Although therapists indicate their fee for service baseline, the HCS has also established their baseline pay for psychological services, therefore making the therapists' baseline fee irrelevant. Thus, if a psychologist's fee is over the insurance provider's base rate, the patient will be sent somewhere else, or the therapist will agree to see the patient at the provider's rate. Most psychologists working in managed care receive less than their full fee because they are competing with master's level therapists who will accept the HCS's rate.

The HCS controls not only the amount of money psychologists get paid for their services, but also when they get paid. Two problems, specific to managed care, often arise in regards to receiving payment for services: (a) Therapy begins with a managed care patient before the therapist solidifies what he or she will receive for his or her services, or (b) the therapist continues to provide services before he or she has received payment for services he or she has already performed. The first problem can be avoided if it is made clear to the patient during informed consent that the onset of therapy is contingent on the patient's insurance company's willingness to solidify a payment agreement with the therapist. Obviously, with familiarity of an insurance provider this may not be a problem. As for the second point, delayed payment is a risk one takes when working within the HCS. Again, psychologists cannot abandon their clients. Therefore, in this situation, a therapist must bring therapy to a point of resolution and count his/her losses.

The third issue of informed concent for therapists who engage in

managed care treatment is termination. Termination is another informed consent issue which dramatically changes with a managed care patient. Because the therapeutic relationship is controlled by the HCS, therapy may end much sooner than anticipated. Psychologists need to discuss with their patients how paying for psychotherapy through the HCS affects termination: basically, that termination may be decided by the HCS before therapy is completed. It is important that the therapist, during informed consent, document and sign a plan with the patient describing what will happen if payment from the HCS ceases. It may be as simple as the patient agreeing to pay for the remainder of therapy out-of-pocket. Or, the patient may agree to be referred to a low-fee or sliding-scale counseling service for the remainder of his or her treatment. However, if the patient refuses other treatment, even after signing documents that they would do otherwise, the onus of treatment rests upon the active therapist to bring therapy to a point of resolution.

Discussion

The current relationship between clinical psychology and the HCS, unless for treatment of simple AI pathology, creates a situation which often hinders therapists' ability to provide adequate treatment for the clients they serve. Because psychologists are bound by their ethics to (a) provide adequate treatment and (b) not abandon their clients, many psychologists are caught in an ethical and legal dilemma when one of two things happen: Either (a) their client's insurance company ceases paying for treatment or (b) they've begun short-term treatment with a patient who actually requires long-term treatment.

An ethical and legal case can be made that the mere reduction of symptoms does not constitute adequate treatment. If HCS payment ceases or longer treatment is needed, the only ethical alternative for a therapist is to continue seeing the patient at a reduced, out-of-pocket rate or for gratis until therapy has reached satisfactory resolution. Although therapists risk this scenario with any patient, the chance of it happening with a third-party paying patient is substantially increased.

The AI/PD third-party paying patient is a good example of how the current relationship between clinical psychology and the HCS is incompatible. The literature shows that when treating AI/PD patients with time limited therapy, usually only a reduction of symptoms relative to the patient's pretreatment report of symptoms occurs. Although these patients' positive AI symptoms decrease, they often still meet the criteria for the AI disorder they were being treated for, not to mention the criteria of their premorbid PD they were not treated for.

Inherent in the concept of PDs is their underlying severity and pervasiveness. Therefore, as expected, the pretreatment and posttreatment global functioning levels of AI/PD patients are significantly lower than their AI/NPD treatment counterparts. Two issues have been addressed in this paper: (a) the empirical literature that illuminates the ineffectiveness of brief psychotherapy for AI/PD patients and (b) a psychologist's legal and ethical responsibility to adequately treat the patients he or she serves. Short-term therapy with AI/PD patients, in most cases, does not constitute adequate treatment. The research reviewed in this paper also indicates that only addressing the confounding effects of comorbid PDs on AI treatment may be too restricting. Considering patients whose psychological discomfort is an

issue of trait change rather than symptom reduction broadens the spectrum of patients whom managed care psychotherapy inadequately serves.

In light of the research offered, and because trait change patients require more therapy than the HCS offers, ethical and legal issues arise for therapists who work with third-party paying patients regarding adequate treatment and client abandonment. To terminate therapy because of payment issues before therapy reaches a point of resolution is a clear violation of professional ethics. In looking at the specific instance of treating an AI/PD patient through third-party payment, the issue is what do therapists do when their patients do not reach a level of healthy functioning within the allotted number of therapy sessions provided by the patient's insurance company. Although this scenario is prevalent in private practices, clinics, and hospitals today, some therapists have chosen to not work briefly with any patients who exhibit trait change issues, managed care paying patients or not.

A large number of psychologists now see adequate treatment as "I'll do the best for the patient I can in X (number of) sessions," as opposed to "I cannot adequately treat this patient in X (number of) sessions." This managed care psychotherapy mind set, which has become prevalent in practice and graduate psychology programs today, is not in line with a psychologist's ethical mandate for adequate treatment of patients. Many psychologists blame the HCS for their inability to adequately treat those they serve. Because many psychologists cannot see their own value, that is, the value of good psychotherapy, they have allowed themselves to be controlled by the HCS. Rather than taking a stand for themselves and the integrity of the profession, by not accepting the substandard limitations the HCS has

imposed, many psychologists have conveniently forgotten their professional ethics and theories and have succumbed to the practices of the HCS. It's time the field of psychology interprets its own projections and defenses of repression and denial in the area of managed care.

REFERENCES

Ackley, D. C. (1997). Breaking free of managed care. New York: Guilford Press.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. American Psychologist, 47, 1597-1611.

Barlow, D. (1991, June). The treatment of anxiety and panic disorders. Conference sponsored by the Mid-Atlantic Educational Institute, Absecon, NJ.

Bergin, A. (1971). The evaluation of therapeutic outcomes. In A. Bergin & S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change (pp. 217-270). New York: Wiley.

Borus, J. F., Olendzki, M. C., Kessler, L., Buens, B. J., Brandt, U. C., Broverman, C. A., & Henderson, P. R. (1985). The offset effect of mental health treatment on ambulatory medical care utilization and changes. Archives of General Psychiatry, 42, 573-580.

Brody, D. S. (1980). Physician recognition of behavioral, psychological and social aspects of medical care. Archives of Internal Medicine, 140, 1286 1289.

Cacciola, J. S., Rutherford, M. J., Alterman, A. I., McKay, J. R., & Snider, E. C. (1996). Personality disorders and treatment outcome in methadone maintenance patients. Journal of Nervous and Mental Disease, 184, 234 239.

Canter, M., Bennett, B., Jones, S., Nagy, T. (1994). Ethics for psychologists: A commentary on the APA ethics code. Washington, DC: American Psychological Association.

Casey, P., Meagher, D., & Butler, E. (1996). Personality, functioning, and recovery from major depression. The Journal of Nervous and Mental Disease, 184, 240-245.

de Silva, P. & Eysenck, S. (1987). Personality and addictiveness in anorexic and bulimic patients. Personality and Individual Differences, 8, 749-751.

Did you know? (1995, Summer). Advance, 5.

Elliott, T., Jackson, W., Layfield, M., & Kendall, D. (1996). Personality disorders and response to outpatient treatment of chronic pain. Journal of Clinical Psychology in Medical Settings, 3, 219-234.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. Journal of Consulting Psychology, 16, 319-324.

Fahy, T. A., Eisler, I., & Russell, G. F. M. (1993). Personality disorder and treatment response in bulimia nervosa. British Journal of Psychiatry, 162, 765-770.

Fiedler, J. L., & Wright, J. B. (1989). The medical cost offset effect and public health policy: Mental health industry in transition. New York: Praeger.

Gonik, U. L., Farrow, I. J., Meier, M. L., Ostman, G. S., Frolick, L. D. (1981). Cost-effectiveness of behavioral medicine procedures in the treatment of stress-related disorders. American Journal of Clinical Biofeedback, 4, 16-24.

Hardy, G. E., Barkham, M., Shapiro D. M., Stiles, W. B., Rees, A., & Reynolds, S. (1995). Impact of cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. Journal of Consulting and Clinical Psychology, 63, 997-1004.

Jones, K. R., Vischi T. R. (1979). Impact of alcohol, drug abuse, and mental health treatment on medical care utilization: A review of the research literature. Medical Care, 17 (Suppl. 2), 1-82.

Kessler, L. G., Steinwachs, D. M., & Hankin, J. R. (1982). Episodes of psychiatric care and medical utilization. Medical Care, 20, 1209-1221.

Kessler, L. G., Cleary, P. G., & Burke, J. D. (1985). Psychiatric disorders in primary care. Archives of General Psychiatry, 42, 583-587.

Kinney, R. K., Gatchel, R. J., Polatin, P. B., Fogarty, W. T., & Mayer, J. G. (1993). Prevalence of psychopathology in acute and chronic low back pain patients. Journal of Occupational Rehabilitation, 3, 95-103.

Kosten, T. A., Kosten, T. R., & Rounsaville, B. J. (1989). Personality disorders in opiate addicts show prognostic specificity. Journal of Substance Abuse and Treatment, 6, 163-168.

Massad, P. M., West, A. N., & Friedman, M. J. (1990). Relationship between utilization of mental health and medical services in a VA hospital. American Journal of Psychiatry, 147, 465-469.

Mental health: Does therapy help? (1995, November). Consumer Reports, 743-749.

Miller, I. (1996). Time-limited brief therapy has gone too far: The result is invisible rationing. Professional Psychology: Research and Practice, 2, 567 576.

Mumford, E., Schlesinger, H. J., Glass, G. L., Patrick, C., & Cuerdon, T. (1984). A new look at evidence about reduced cost of medical utilization following mental health treatment. American Journal of Psychiatry, 141, 1145-1158.

Norman, D. K., & Herzog, D. B. (1983). Bulimia, anorexia nervosa, and anorexia nervosa with bulimia: A comparative analysis of MMPI profiles. International Journal of Eating Disorders, 2, 43-52.

Nurnberg, G. H., Rifkin, A., Doddi, S. (1993). A systematic assessment of the comorbidity of DSM-III-R personality disorders in alcoholic outpatients. Comprehensive Psychiatry, 34 (6), 447-454.

Oldham, J. (1992). Diagnosis and treatment of personality disorders. Psychiatric Quarterly, 63, 413-424.

Orleans, C. T., George, J. K., Houpt, J. L., & Brudie, H. K. (1985). How primary care physicians treat psychiatric disorders: A national survey of family practitioners. American Journal of Psychiatry, 142, 52-57.

Polonsky, I. (1993, May/June). How to write treatment reports for managed care. The California Therapist , 5 (3), 29-32.

Reich, J.H. (1988). DSM-III personality disorders and the outcome of treated panic disorder. American Journal of Psychiatry, 145 , 1149-1152.

Sanders, R. K. (1998). Integrity in the age of managed care. Journal of Psychology and Christianity, 17, 101-109.

Sato, T., Sakado, K., Sato, S., & Morikawa, T. (1994). Cluster A personality disorder: A marker of worse treatment outcome of major depression? Psychiatry Research, 53, 153-159.

Schlesinger, H. J., Mumford, E., & Gene, V. (1983). Mental health treatment and medical care utilization in a fee-for-service system: Outpatient mental health treatment following the onset of a chronic illness. American Journal of Public Health, 73, 422-429.

Seligman, M. (1995). The effectiveness of psychotherapy. American Psychologist, 50, 960-974.

Shea, M. T., Pilkonis, P.A., Beckham, E., Collins, J.F., Elkin, I., Sotsky, S.M., & Docherty, J.P. (1990). Personality disorders and treatment outcome in the NIMH treatment of depression collaborative research program. American Journal of Psychiatry, 147, 117-118.

Sheehan, D., Ballenger, J., & Jacobsen, G. (1980). Treatment of endogenous anxiety with phobic, hysterical and hypochondriacal symptoms. Archives of General Psychiatry, 37, 51-59.

Smith, M., Glass, G., & Miller, T. (1980). The benefits of psychotherapy. Baltimore: Johns Hopkins University Press.

Sorenson, R. (1998). Is psychotherapy dead? Journal of Psychology and Christianity, 17, 110-124.

Steenbarger, B. N. (1994). Duration and outcome in psychotherapy: An integrative review. Professional Psychology: Research and Practice, 25, 111-119.

Stevenson, J., & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. American Journal of Psychiatry, 149, 358-362.

Strober, M. (1981). A comparative analysis of personality organization in juvenile anorexia nervosa. Journal or Youth and Adolescence, 10, 285-295.

Thompson, L., Gallagher, D., & Czirr, R. (1988). Personality disorder and outcome in the treatment of late-life depression. Journal of Geriatric Psychiatry, 21, 133-146.

Wonderlich, S. A., Swift, W. J., Slotnick, H.B., Goodman, S. (1990). DSM-III-R personality disorders in eating-disorder subtypes. International Journal of Eating Disorders, 9, 607-616.

VITA

NAME:

Jeffrey L. Schwieger

EDUCATION:

Rosemead School of Psychology Clinical Psychology	Psy.D.	(Cand.)
Rosemead School of Psychology Clinical Psychology	M.A.	1996
California State University, Fullerton Psychology	B.A.	1993
Fullerton College General	A.A.	1991

INTERNSHIP:

Jerry L. Pettis Memorial Veteran's Hospital, Loma Linda, CA	1998 - 1999

PRACTICA:

L.A. County USC, Dept. of Child Psychiatry	1997 - 1998
Center for Family Therapy	1996 - 1997
La Puente High School	1995 - 1996

EMPLOYMENT:

Center for Family Therapy Psychological Assistant	1997 - 1998
La Puente High School Interventionist	1996 - 1997